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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DIANA LYNN PATWELL, a.k.a. DIANA LYNN MIKLANCIC, a.k.a. DIANA LYNN DARRINGTON 5175 Abbott Road Penryn, CA 95663 Registered Nurse License No. 423104 Nurse Anesthetist Certificate No. 1884 Respondent.	Case No. 2009-177 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License No. 423104

2. On or about August 30, 1988, the Board issued Registered Nurse License Number 423104 to Diana Lynn Patwell, also known as Diana Lynn Miklancic and Diana Lynn Darrington ("Respondent"). Respondent's registered nurse license was in full force and effect at

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all times relevant to the charges brought herein and will expire on November 30, 2009, unless renewed.

Nurse Anesthetist Certificate No. 1884

3. On or about June 4, 1992, the Board issued Nurse Anesthetist Certificate Number 1884 to Respondent. Respondent's nurse anesthetist certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2009, unless renewed.

STATUTORY PROVISIONS

4. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

7. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation

which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. At all times herein mentioned, Respondent was employed as a certified registered nurse anesthetist (CRNA) at South Kaiser Permanente Hospital, Sacramento, California.

10. On June 28, 2006, Respondent was assigned to the labor and delivery unit during the evening shift. At the end of her shift and during the transfer of patient care to the on-coming day shift CRNA, Debbie M., Respondent reported that she suspected that one of her (Respondent's) lumbar epidural placements may have resulted in the catheter being placed in the subarachnoid space, producing an intrathecal catheter rather than the usual epidural catheter. Respondent warned Debbie M. that even though she could not aspirate cerebrospinal fluid, the catheter should be considered an intrathecal catheter until proven otherwise because of the exaggerated response that was produced when a small amount of local anesthetic was injected into the catheter. After receiving the report, Debbie M. relayed the information to Dr. Michael L., who was the on-coming anesthesiologist and relief for Dr. Carolyn B. Dr. B. was the supervising anesthesiologist at the time of Respondent's shift. Dr. Michael L. went directly to the patient's room, evaluated the catheter for possible intrathecal placement, and was able to aspirate cerebrospinal fluid.

11. Following the administration of the local anesthetic by Respondent, the patient became "woozy" and had to lie down. The patient complained of being "very numb" and became quite sleepy to the point of being difficult to rouse for the next 60 to 90 minutes.

The patient also reportedly passed out after her epidural and was given ammonia (smelling salts). The patient came to, but could not swallow. Both anesthesiologists noted that the patient became hypotensive (blood pressure of 85/50), requiring medication to support her blood pressure. Fetal heart tones were also noted to have fallen to 70 beats per minute for 60 seconds with uterine contractions.

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that Respondent was guilty of gross negligence within the meaning of Regulation 1442, as follows:

a. Respondent failed to evaluate the patient for local anesthetic toxicity and prepare to possibly protect the patient's airway with endotracheal intubation.

b. Respondent failed to document in the anesthetic record the patient's hypotension, loss of consciousness, and inability to swallow.

c. Respondent failed to take or document the patient's vital signs after the initial placement of the catheter.

d. Respondent failed to notify Dr. B. of the incidents described in paragraphs 10 and 11 above or convey to Dr. B. information regarding the patient's clinical situation that potentially could have become a catastrophic event.

e. Respondent violated the anesthesia department's protocol for the safeguarding of a patient with an intrathecal catheter, as follows:

1. Respondent failed to notify Dr. B. that she suspected an intrathecal catheter placement;

2. Respondent failed to return to re-evaluate the catheter;

3. Respondent failed to place signs on the PCA pump, IV pole attached to the patient's bed, or anesthesia record alerting the personnel caring for the patient that an intrathecal catheter was present;

4. Respondent failed to label the catheter as intrathecal and not epidural near the catheter port; and

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5. Respondent failed to notify the charge RN or the RN caring for the patient that the catheter was suspected to be intrathecal.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 through 11 above.

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that Respondent committed acts constituting unprofessional conduct, as set forth in paragraph 12 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 423104, issued to Diana Lynn Patwell, also known as Diana Lynn Miklancic and Diana Lynn Darrington;

2. Revoking or suspending Nurse Anesthetist Certificate Number 1884, issued to Diana Lynn Patwell, also known as Diana Lynn Miklancic and Diana Lynn Darrington;

3. Ordering Diana Lynn Patwell, also known as Diana Lynn Miklancic and Diana Lynn Darrington, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 9/30/08.

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

phd: 09/18/2008